Breast and Cervical Cancer Advisory Council Meeting
April 29, 2011
10:00 a.m. - 3:00 p.m.

Agenda Item	Discussion	Action Items
Welcome and Introductions	Council Members and State Staff Introduced themselves	N/A
Announcements and Chair Comments	None	N/A
CDPH-State-of-the-State (Dr. Lyman)	Federal Budget – The appropriations bill contained unallocated cuts of about $750M for Center for Disease Control and Prevention (CDC). Cuts are to be outlined by mid-May. Every part of CDC is in jeopardy of losing funding but this cut is a small portion of CDC's funding and they may be able to shift money, which would have minimal impact on categorical funding. **Health Care Reform (HCR) –** Funds have been set aside for the Prevention and Public Health Fund. Funds started last year with around $500M. The funding amount is small but the funding is high profile. In fiscal year (FY) 2012, the funding is expected to increase to $750M. There is a portion of the funding that has been earmarked for breast and cervical cancer programs. HCR in general is moving forward. Most of the current provisions in HCR legislation will be sustained but some pieces will be compromised. This legislation will result in a greater number of people having access to healthcare. There was a question posed as to whether there will be enough providers to accommodate people obtaining healthcare as a result of HCR. The 1115 Waiver is part of California's plan for implementation of HCR. State Budget – The fiscal crisis continues. Half of the deficit will be resolved with cuts. The other half is still in play. The Governor would like to put the other half on the ballot for the people to decide on extending tax increases. The budgetary process has shifted for Every Woman Counts (EWC). EWC was	N/A

	viewed as a fixed cost program and was expected to spend within the budget allocation. However, EWC's increasing caseload and clinical claims costs exceeded the fixed budget. EWC now uses an appropriations process that allows for flexibility in caseload. Assumptions and Estimates documents have been produced which allows the legislature to make policy decisions about funding. This process has also increased transparency to stakeholders and the Legislature.	
Breast & Cervical Cancer Treatment Program (BCCTP) Update	The cut off for BCCTP data collection in the report is March 31, 2011. Provider update – The Majority of enrollments into BCCTP are through EWC providers. Other enrollments include Family Planning Access, Care, and Treatment (FPACT), private and other government agencies. Provider participation is a concern due to the new case management fee structure. The Cancer Detection Section (CDS) is keeping a watch on the number of providers participating, data submission and case management. Impact of EWC policy changes -- Initially there was a reduction of about 100 cases per month partly due to some confusion about whether BCCTP had stopped treatment when EWC stopped new enrollments. Over time, the numbers leveled out. Numbers started to increase when EWC implemented new program policies.	**Report requests:** *What percent of all breast and cervical cancer in CA since January 2002 is represented by BCCTP? Looking to assess program impact. *Over 10 year period, has there been any change in what's been diagnosed by year? *Council Member requested to see a breakdown of Table 1 by race/ethnicity including language *Report of breakdown of State vs. Federal portions of the treatment program *Does percentage of women treated by county match up with the incidence rates by county or population size?

Workgroup Update (Sequence change)	The Breast Expert Workgroup is developing the fourth edition of the Breast Diagnostic Algorithms (Dr. Wagman is the chair). There has been national and international interest in the algorithms. CDS is aiming to go to print in July. CDS is working on providing more clarity on what the process should be when certain risk factors are identified. The Cervical Expert Workgroup is working on the cervical curriculum. Progress has been slower than expected due to staff turnover and other issues. CDS staff has contributed guidance and clinical expertise to the group. Field testing of the curriculum of 130 slides will hopefully happen in the next month or two. CDS will apply for CME credit and identify faculty. Target audience for the training is the primary care provider. The curriculum is driven by meeting CDC quality indicators for cases with abnormal results with complete follow-up.	*If Council knows of cervical providers that could serve as faculty for the training please forward their names to CDS.
Cancer Detection Section Report	<u>Policy Updates</u> • Enrollment has increased since program re-opened December 1, 2010. This is reflected in the clinical claims process. Cervical enrollments dipped slightly as a result of the policy changes but not significantly. • CDS expects the case management fee change (No longer paying for normal screening records) to result in a $7M savings. CDS has not received complaints, resistance, or seen a decline in number of providers. It might be too early to see any changes in provider behavior as a result of the change in case management fees. CDS is keeping a close eye out to see if there will be decreases in the report of normal mammography results. • Digital Mammography has not caused billing to increase. Currently, there is no effect of digital mammography rates on billing, but when the bill sunsets on January 1, 2014, CDS will likely see an increase in clinical claims costs due to the higher rate paid for digital mammography. • Medi-Cal reimbursement rates will decrease by ten percent.	*1115 Waiver (In response to possibility of CDC funding changing as a result of the 1115 Waiver) – The Council would like to develop a letter to present to the State about how to spend federal dollars. Something to the effect of: “BCCAC advises that it is preferential to maintain current funding…Continue to maintain/retain current structure of the allocated budget…Want budget to be maintained for cancer screening and diagnoses...keep cancer independently funded. *Annual Report - The Council

	• The Provider Evaluation Workgroup is looking at provider data submission to check for compliance of how/what data is submitted based upon contractual obligations. The Workgroup is looking at the outcome data the provider submits compared to what the provider is paid. There have been two voluntary provider disenrollments, but most providers were responsive to letters sent out asking for data to be submitted. The group is also looking into providers with many denied claims to identify technical assistance and training needs. • **1115 Waiver (Bridge to Reform)** – Current Medi-Cal/Medicaid eligibility is 100 percent of Federal Poverty Level (FPL) with links being required (disability, blind, have children). Medicaid is being expanded to include a higher level of income, up to 133 percent of FPL, without the links. People will be able to access care provided by this waiver at the county level (26 counties have applied for funding). It is being referred to as the Low Income Health Plan (LIHP). LIHP development is at the discretion of the county. They decide what to cover and what not to cover and it can vary by county. Program eligibility is based on citizenship because the dollars are federal. Some counties will cover individuals up to 200 percent of FPL. Implementation of 1115 waiver will begin in June 2011. CDS has met with Department of Health Care Services (DHCS) for preliminary analysis of how this will affect EWC. The impact on CDS will be addressed in upcoming Estimates Packages. CDC's breast and cervical cancer screening grant funding will be in question when 1115 waiver is fully implemented. <u>Reporting Updates</u> • The Annual Report to the Legislature contains the number of women screened in FY 2008-09. It also contains the number of women diagnosed using registry data for 2007 and it shows the treatment status of those women. The report includes breast cancer data only. • The 2010 Trailer Bill included language that required CDS to produce quarterly reports to be submitted to the legislature. • The **Core Program Performance Indicators (CPPI)** – CDS focuses effort on meeting these federal quality indicators. All enrolled providers in the	would like to be informed when the Annual Report is published *Quarterly Report – Council would like to see a breakdown in diagnostic breast procedures if such a breakdown exists. Send out alerts to Council Members when quarterly reports are posted *For the federal subset the council would like to see a breakdown of rarely vs. never screened. *The Council would like to be consulted as part of the rulemaking process

state didn't meet complete follow up of the abnormals for cervical. This is the most difficult indicator to meet nationally as well. The percent of abnormal breast screening is at 92 percent. The PCPs that are a part of the federal subset of data sent to the CDC, have data navigators to provide support with improving data submission. The federal subset meets all eleven CPPI.

Budget Updates

- CDS has four funding sources: Proposition 99, 1 cent tobacco tax [Breast Cancer Control Account (BCCA)], CDC federal funds, and General Fund (GF). BCCA funding was highlighted because in 2009-10 when the program implemented policy changes; there were unspent funds and costs savings of about $4M. This funding will be carried over into FY 2011-12.

- The EWC November 2010 Estimate Package can be found on the CDS website. There was a savings of $10.6M in GF monies in the current year (FY 2010-11) due to the following: a five month delay in the passage of the Budget Act, a change in the amounts paid for case management from $50 for all case management to $50 for abnormal results and $0 for normal results, and a reduction in the Medi-Cal radiology rate. The case management fee structure change went into effect July 1, 2010. Page nine of the Package describes the methodology used to arrive at projections (percent change). FY 2008-09 was used as the basis for FY 2011-12 projections as it was the last time EWC was fully operational with no policy changes (serving women aged 40-49 and open to new enrollments). Expected FY 2010-11 caseload projections based on 2008-09 is approximately 393K women.

- CDC Federal Grant – In FY 2010-11, CDS received an increase of $859K and all of it was spent on clinical claims. For FY 2011-12, CDS expects to either be flat funded or possibly receive a small reduction.

Response to Audit

- EWC was audited by Department of Finance and Bureau of State Audits (BSA). This update focuses on BSA findings and recommendations as well as CDS' response to those recommendations. For FY 2010-11, 78 percent

	of funds went to clinical claims, eight percent to salaries and operating expenses, seven percent to local assistance contracts, three percent to other support contracts, and four percent to processing claims. In FY 2011-12, there is a decrease in salary percent to overall budget. There is also a decrease in contract cost percent to overall budget. In FY 2008-09, CDS moved $5M from BCCA local assistance and support to clinical claims. In FY 2009-10, $1.5M was moved from local assistance to clinical claims. In FY 2010-11, $1.7M was cut from support. • CDS is currently in the process of promulgating regulations. Staff has been assigned to develop regulations. Also, an internal CDS team with content expertise and a California Department of Public Health regulations team are involved in the process. • Single Point of Enrollment/Identity (SPI) – One goal of SPI is to decrease the number of duplicate enrollments into EWC. One proposal is to use the EWC Consumer 800 Number as the central enrollment point. The Council expressed concern about having women only enter the program through the 800 Number and perceived this to be a potential barrier to enrollment. CDS is exploring different mechanisms to decrease barriers. The programming work will start no earlier than January 2012, after the transition of the DHCS fiscal intermediary from Hewlett Packard to Affiliated Computer Services (ACS). CDS will also begin collecting social security numbers as a way to identify individuals, but not a required element for enrollment or eligibility criteria. <u>Future Issues</u> • EWC local presence model – The current regional field staff structure is skeletal. CDS staff conducted provider trainings in San Diego (SD) and Los Angeles (LA) while the regions were not covered by contractors. There are currently six regions in the state covered by the California Health Collaborative (CHC) including the addition of SD and LA. CDS explored the possibility of a single entity model, but there would be many barriers to implementing this model (high travel costs, local presence, equipment, etc.). The current proposal is to continue to contract with existing experienced contractors in order to maintain the infrastructure in each region for provider network support and community collaboration for health	*The Council would like to know the percent of duplicate enrollments

	education efforts. CDS proposed to consolidate all of CHC's contracts into one contract, and have separate contracts for other regions. This will cut administration and overhead costs. Communication with nursing staff has significantly increased with CHC overseeing several of the regions. The Scope of Work (SOW) for the regions is directly related to meeting CPPIs. CDS is hoping to increase staffing to better address the regions' needs. Two contractors have already expressed to CDS that they will no longer be able to implement a SOW if the funding remains the same and will be forced to pull out of future contract opportunities. The Council was in agreement with an increase in funding to the regions to maximize staffing to continue health education activities and support access for screening services.	
Council Discussion (Dr. Michael Policar, UCSF)	<u>Cervical Cancer Screening Guidelines Update</u> • Women should have first Pap test at 21 years of age. At ages 21-29, a Pap test is recommended every two years. At ages 30-65, a Pap test is recommended every three years. There are exceptions for women with compromised immune systems. There are three scientific entities/bodies that provide screening recommendations for cervical cancer. When two out of three of these entities/bodies adopt the recommendation that women should not receive Pap screening under the age of 21, FPACT will stop reimbursing for Pap tests on women less than 21 years of age. FPACT provides 800,000 Pap tests per year. The research findings suggest that women are being over screened based on the average screening interval in a population of women. Currently, screening is occurring every 15 months and the intervals need to be extended to 22-24 months. Sexual history is important to evaluate Sexually Transmitted Disease risk but not screening intervals for Pap tests. Screening patients based on number of partners is irrelevant. The recommendation is to start at age 21 as Human Papillomavirus is highly prevalent and takes about ten years for cervical cancer to develop so it can be identified and treated before it becomes serious. The evidence suggests that Pap tests before the age of 21 does more harm than good.	

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Council Members	Attendance	
	Present	Absent
Lawrence Wagman	√	
Diane Carr	√	
Rev. Tammie Denyse		√
Lydia Howell		√
Marion Kavanaugh-Lynch	√	
Claire Mills	√	
Michael Policar	√	
Sandra Robinson	√	
Beverly Rodriguez		√
Susan Shinagawa	√	
Carol Somkin	√	
Joan R. Bloom	√	

State staff	Attendance	
	Present	Absent
Dr. Donald Lyman, CDIC Chief	√	
Josie DeLeon, CDIC Assistant Chief		√
Caroline Peck, CDCB Brach Chief	√	
Clarissa Poole-Sims, CDCB Assistant Branch Chief		√
Katie Owens, CDS Acting Chief	√	
Stephanie Roberson, CDS Assistant Chief	√	
Betsy Barnhart, CDS Fiscal and Legislation Unit Chief	√	
Manuel Chavez, BCCTP	√	
Candace Moorman, CDS Continuous Quality Improvement	√	
Kristine Selmar, CDS, Chief, Administration Unit	√	
La Roux Pendleton, CDS, Fiscal & Legislation Unit	√	
Kathleen Yelle, Manager, BCCTP	√	
Carmen Alexander, Manager, BCCTP	√	